STATE OF WASHINGTON

OFFICE OF FINANCIAL MANAGEMENT

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May 18, 2001

TO: Potential State Planning Grant Bidders

FROM: John Toohey, RFP Coordinator

SUBJECT: AMENDMENTS TO RFP #01-700

The following answers are submitted in response to questions from Consultants who submitted letters of intent to bid on the State Planning Grant on Access to Health Insurance project. In addition, three minor addenda to the RFP simplify and clarify the RFP to assist Consultants in completing their proposals.

1. Q: Does the AGENCY require some minimum level of Contractor on-site presence during this project?

   A: The AGENCY does not specifically require the Contractor to maintain an on-site presence during the project. However, we expect that the fluid nature of the work will require considerable interaction with project staff, workgroups / advisory groups and stakeholders, and we believe that this interaction will be difficult without a local Washington presence. We are open to creative suggestions for achieving close interaction.

2. Q: Will there be any office space available for Contractors to use at or near the Agency's office?

   A: Currently, the AGENCY cannot guarantee free, available office space. A recent earthquake in the Olympia area has impacted the availability of office space, and the project office is currently self-contained in a very modest facility. However, we are willing to explore potential alternatives with the successful Consultant.

3. Q: The timeline for submitting proposals is extremely tight; will the AGENCY extend the proposal due date?

A: We recognize that the timeline is tight but we do not anticipate extending the proposal due date.

4. Q: After Part 3 (Less Defined Scope of Work), the RFP includes a section entitled "Other Tasks." Are these "Other Tasks" considered to be part of Part 3 or part of Parts 1 and 2 of the project?

   A: The section entitled "Other Tasks" is included in Part 3 work not yet fully defined. (It may be helpful for Consultants to review Section 1.4 of the RFP, which describes funding for this work.)

5. Q: Please verify that Goal 4, task 17 should be addressed in the Technical Proposal, but that the "Less Defined Scope of Work" under part 3 should not.

   A: Goal 4, task 17, as well as the remaining tasks of Goal 4 described in the "Less Defined Scope of Work", should be included in the technical proposal. Pages 21 and 29 of the RFP ask that suggestions for a detailed approach on the less defined tasks be included for our consideration.

6. Q: Under "Other Tasks: Final Report," the RFP on page 23 states "… it is likely additional assistance will be desirable to complete the documentation and packaging of the (HRSA) report." Would submitting written deliverables in a format that will serve as stand-alone chapters or sections of the OFM HRSA report meet this task's requirements? Is additional work by the Contractor required, and if so, could you provide some more guidance?

   Q: The HRSA Final Report is referred to on page 22 of the RFP under Less Defined Scope of Work, heading of Other Tasks. Please verify that assistance with the HRSA report should be included in "Less Defined Scope of Work", rather than the HRSA report being a deliverable for Parts 1 and 2.

   A: Assistance with the HRSA report should be included in Part 3, the "Less Defined Scope of Work." Project staff hopes to build the HRSA report from deliverables produced by the Contractor. At this point we are unable to provide more guidance, however, we do not expect that the Contractor will need to provide much additional assistance to complete the HRSA report. It may be helpful for Consultants to review Section 1.4 of the RFP, which describes funding for this work.

7. Q: We were not sure of the correct interpretation of the two part proposal scoring. For proposals that make it to the second round (oral presentations), will the first round's score (up to 500 points) be carried over or not?

   A: Scores from the first round (steps 1-3 described in Section 5.1) will not be carried forward. Consultants invited to make oral presentations will be scored on their business references and their oral presentation and the apparent successful Consultant will be determined from the sum of these two scores.

8. Q: Are copies available of the Washington proposal to HRSA?

A: The Statement of Project Goals and Project Description from the Washington proposal to HRSA are attached to the end of this RFP Amendment. Consultants should note that the proposal was submitted to HRSA in July 2000, almost one year ago. Since that time the environment in Washington has changed. We suggest that Consultants focus their attention on work described in the RFP #01-700 released on May 9, 2001.

9. Q: Should the cost and technical proposal be bound together or separately?

A: As described in Section 4.1, proposals include four major sections. All sections should be bound together as a single document, with tabs separating the sections.

10. Q: In TASKS 7-8, a technical workgroup is referenced. Who makes up the technical workgroup? Is the AGENCY responsible for organizing the technical workgroup or the contractor?

Q: On page 14, Task 4 of the proposal, an advisory panel is referenced. Who makes up this advisory panel? Is the AGENCY responsible for organizing this panel or the Contractor?

Q: Will the Agency be responsible for identifying, organizing and convening this technical workgroup as well as the advisory panels as referenced in the RFP? What is the anticipated size and composition of these groups? Is it recommended that the consultant provide suggestions regarding general composition of the workgroup and advisory panels?

A: The governance structure for the project includes project staff (referenced in Section 1.6), a management oversight panel (MOP) and a variety of technical and policy work groups / advisory panels made up of public and private stakeholders. These groups have been noted in the RFP where we can clearly define their involvement at this time. Consultants should note that we expect there to be a work group / advisory panel to provide guidance and serve as a sounding board <u>for each goal</u>. As described in Section 1.6, the AGENCY expects to organize and co-ordinate these work groups, however we do expect that the Contractor will interact with them throughout the project.

We would very much appreciate suggestions from Consultants for the make-up of these groups. We hope to keep group size small (i.e. we anticipate fewer than twenty members in each group.)

11. Q: How many of the prospective bidders will be invited to the oral presentation scheduled for June 6, 2001? Will there be an oral presentation schedule with designated time slots assigned to each presenting firm? If so, will you accept requests for scheduling preference?

A: We don't know exactly how many Consultants will be invited to make oral presentations. Oral presentations will be scheduled with designated time slots for each

Consultant. Although we cannot promise to accommodate specific Consultant requests for scheduling, we will certainly try to do so.

12. Q: In TASK 1, Deliverable 1.2: Project Status Reports, it states that the Contractor shall submit bi-weekly status reports. Please clarify bi-weekly, i.e. what will be the expected frequency of delivery, once every two weeks or twice per week? Also, what will be the acceptable form of delivery for these reports: e-mail, fax, US mail, or a combination of these methods?

    A: We intend that status reports be submitted once every two weeks for the purpose of ensuring that the Contractor and project staffs are in sync, misunderstandings are avoided and problems resolved quickly. Our interest is in the substance of these reports not the process surrounding them. Therefore to support efficient communication and turnaround we prefer e-mail or faxed delivery of a written report. We are not open to verbal status reports.

13. Q: Regarding the report on the Website we were directed to in Task 9, presenting a paper of the Fiscal Policy Center: Policy Choices for Working Families in Washington, there are 3 tables or graphics identified for which the visual (and actual) data were not available on the web-site, or were not viewable. One related to working or non-working families and economic support, the second was labeled "State Expenditures Dependent on Federal Funds", and the third was "Median and Minimum Family Budgets in Washington (Family of 3, 1996)". Can that data be provided?

    A: We appreciate this question as an opportunity to clarify our intent in including the reference in Task 9 and to clarify our expectations for review of data collection methodologies in general.

    We anticipate that the Contractor will be familiar with a variety of studies and the broad body of work completed nationally on the subject of affordability and price sensitivity. We included the reference to Washington only to draw attention to local Washington-specific studies as part of the broader context. We cannot guarantee availability of the data associated with the Fiscal Policy Center (FPC) studies. However, when the Contractor finalizes the data collection methodology for Task 9, if access to the FPC data is needed, we will explore avenues for obtaining the data for the Contractor.

    Consultants should note that for <u>all</u> Goals, (as described for Goal 1, in Task 4), prior to commencement of specific data collection activities we expect that the Contractor will discuss and confirm the recommended data collection methodology with the AGENCY's work group for that goal.

14. Q: Has Washington initiated its own employer survey? If so, how recently?

    A: Washington conducted an employer survey in the early 1990s as part of health care reform efforts.

15. Q: Is it possible to submit a proposal for selected portions of the project?

A: No – as described in Section 4.4.1 (requirements for the Technical Proposal) and as indicated on Exhibit A (the Checklist for Responsiveness), Consultants will be considered non-responsive if they submit a proposal for selected portions of the project. Our strong preference is to work with a single main Consultant who has partnered up with appropriate skills and experience to accomplish all tasks in the proposal. However, as noted in Section 1.10, we have reserved the right to award the tasks to one or more Contractors if deemed to be in the best interest of the project based on proposals submitted.

16. Q: Are there restrictions on page limits and font size?

Q: Are there page limits or suggestions regarding the length for the proposal?

A: The proposal purposefully does not limit the number of pages because we have asked for creative and thorough responses. We recognize the tight time constraints for packaging a complete proposal, and are more interested in allowing time for substantive responses than counting the number of pages submitted. We would appreciate a readable font size (i.e. 12 point).

17. Q: Will the Agency publicly issue a list of consultants who submitted letters of intent to bid?

A: Yes, the list of Consultants who submitted letters of intent is included as follows.

- Abt Associates Inc
- American Institutes for Research
- Battelle
- Clearwater Research w/Boise State University Center for Health Policy
- Foundation for Health Care Quality
- Health Management Associates
- IMR Global-Orion
- Kathleen O'Connor, LLC
- MCPP Healthcare Consulting
- Medimetrix
- MGT
- Oasys
- The Lewin Group
- Third Wave Research
- University of Washington (HPAP) w/ Rutgers University (Center for Health Policy)
- Washington State Hospital Association

18. Q: Will all submitted questions and the answers be shared publicly?

A: Yes, questions and answers will be distributed to all Consultants who submitted letters of intent. In addition, they will be placed on the project web site as addendum to the RFP (located at: http://www.ofm.wa.gov/accesshealth/accesshealth.htm).

19. Q: Would the Agency prefer that we put items such as resumes, organizational charts and budget tables as appendices or in the body of the proposal?

A: Please include all relevant items in the appropriate section of the proposal (i.e. management section; cost section…) as described in Section 4 of the RFP.

20. Q: Will items such as the work plan and technical proposal be treated as confidential if designated as such (whether or not the contract is awarded to the responding consultant)?

A: Items the Consultant wishes to claim as proprietary and exempt from public disclosure must be clearly designated, as outlined in Section 2.12 of the RFP. Please note that the entire proposal cannot be marked as exempt from disclosure. Each page must be individually marked with the word "confidential" printed on the lower right hand corner of the page.

21. Q: What is the state's policy regarding travel reimbursement? Are expenses to be included in the proposal?

A: The sample contract included in the RFP explains some of the approach for expenses (on page 41). Travel is reimbursed at state travel reimbursement rates. The state travel guidelines are available at the following URL address: http://www.ofm.wa.gov/policy/travel.htm. Anticipated travel expenses are to be included in the Cost Proposal, as indicated in Section 4.5.1, Exhibits 4.5.1 and 4.5.2.

22. Q: The RFP described that the contract award is contingent upon the availability of funding. Has the state received the funds from the federal government or must these funds be approved through a state appropriations process?

A: The federal funds have been awarded to the state and no state appropriations process is needed. We are not anticipating any withdrawal of the federal funds.

23. Q: Will the Project Director, Vicki M. Wilson, Ph.D., be the Consultant's primary reporting contact?

A: It may be helpful to know that the project staff has worked together for some time and functions as a cohesive unit, and as a result, the daily management of project activities will be divided among the project staff. Staff assignments will be determined prior to the finalization of the project work plan. As project director, Vicki M. Wilson, will retain ultimate authority and accountability for the AGENCY.

24. Q: May we suggest changes in timing for performing tasks?

A: Yes, please do. Page 10 of the RFP invites Consultants to suggest revisions to the sequence, interaction, and content of the tasks.

25. Q: Would you please clarify that the electronic data sets constructed and documented under Task 6 refer to the conceptual database discussed in Task 3? Please verify that these data sets include data from existing public sources and any supplemental data collected as part of Task 5.

A: Yes, the tasks were intended to portray the design of the initial database in task 3, and the development of the final database as well as additional analytic datasets in task 6 which will include any supplemental data collected in task 5.

26. Q: Will the Agency provide support in gathering program information for Task 8? May we assume that the Agency will assist with identification of sources (state departments and staff) and share already collected data and summaries, etc.?

A: Thank you for this question. It provides us the opportunity to clarify our thinking regarding Task 8 in specific, and Goal 2 in general.

We are concerned that our wording in the Brief Description of Goal 2 will lead Consultants to believe that this entire goal and the tasks included under it (i.e., Tasks 8, 9, 10) are focused solely on public programs. This is not the case.

Tasks 9 and 10 were always intended to broadly address issues of affordability, and access to coverage and care for the uninsured (i.e., long-term uninsured, episodically uninsured, at high risk of becoming uninsured), whether or not these populations are linked to public programs.

Upon reflection of Task 8, we are broadening the focus of the task to include pathways to coverage beyond publicly sponsored, community, and safety-net avenues. We are interested in understanding from a variety of perspectives the entire array of options available to people as their life circumstances change, and how these options overlap and link and create gaps. For example, this revised view of pathways to coverage and access should include employer options, options for the self-employed and other individuals that may not have group coverage, including those retiring prior to Medicare age. Language used in Task 8 regarding requested information, descriptions, and graphics is still relevant and should simply be applied, as appropriate, to this broader focus. The AGENCY does intend to provide support with this task.

27. Q: What are the Agency's expectations regarding the public dialogs mentioned in Task 11? How should this be approached in the proposal and what, potentially, would the Agency provide to support, for example policy support, funding or regulatory waivers, these public dialogues?

Q: Is the primary goal for the public dialogs to raise awareness of the problem of the uninsured or to gain specific input regarding potential solutions to the problem?

Q: When the groups are convened for the public dialogs, will the Agency provide the meeting planning logistics, mailings of invitations, room rental, etc. or should these tasks and the expenses be included in the proposal?

A. We appreciate the opportunity to clarify expectations for Task 11 and Deliverable 11.1. In this task we are asking the Contractor to design and develop a format or formats for public dialogs with different audiences (e.g., policy makers, leaders in health care, community activists, residents-in-general), develop associated materials to guide discussions in these public dialogs (e.g., a training manual for facilitators including questions and background information), and to provide a cost estimate for conducting the recommended public dialogs. There are multiple purposes for the dialogs, including:

- Facilitate learning and raise awareness regarding the problems of the uninsured;
- Gain specific input regarding potential solutions to the problem;
- Improve final recommendations and implementation plans for initiatives to improve / maintain access to coverage and care.

Design and development of the public dialog formats must consider the context of Washington's health care, economic, and citizen-activism environments; and should make significant use of the information and analyses resulting from the work of this grant. We anticipate that the Contractor will want to work closely with the AGENCY and advisory workgroup in completing this task.

Task 11 DOES NOT include conducting the public dialogs. The actual implementation of the public dialogs may fall under the auspices of the "Less Defined Scope of Work" in Part 3, or may require that the AGENCY seek additional revenue sources.

Additional Points for Clarification and Simplification

The following points are included to clarify and simplify the RFP.

1. Goal 1, Task 1 – Work Plan and Timeline.
   As described in the RFP, Task 1 reads, "…Specifically, it must present all tasks and deliverables with begin and end dates, person(s) responsible, and number of hours or days proposed for <u>each person</u> on each task or deliverable." This has been revised to exclude the reference to each person and should now read, "Specifically, it must present all tasks and deliverables with begin and end dates, person(s) responsible, and number of hours or days proposed for each task or deliverable." Note that "person(s) responsible" refers to the person(s) leading the task.

2. Goal 1, Task 4 – Data Gap Analysis; and Technical Proposal Section 4.4.1 - Project Methodology
   In Goal 1, Task 4 and in the description of the Technical Proposal, Section 4.4.1, we have asked Consultants to include information regarding their experience. It is <u>not</u> our intent to have Consultants duplicate descriptions of their experience already included in their Management Proposal, Section 4.3.2. Therefore, in Goal 1, Task 4 and in the Technical Proposal, Section 4.4.1, Consultants should only describe experience where they feel that it is important to supplement the information described in their Management Proposal.

3. Goal 3A, Task 13 – Analysis of Initiatives and Issues.

Consistent with our interest throughout the project in focusing on information gathering, analysis and recommendations that prepare Washington now for challenges in the future, the AGENCY is very interested in having this summary identify new initiatives that would allow Washington to adapt to future changes in the health care environment.

8. Statement of Project Goals

This planning grant will provide the resources and technical assistance needed by Washington State to develop a six-year plan, the goal of which is to provide access to affordable health coverage to all residents. In light of the lessons learned from earlier state and national health care reform efforts, Washington plans to explore how best to get closer to the goal of universal access through incremental steps and substantial collaboration among all vested parties, public and private.

At the end of the planning grant, we will have achieved the following goals:

- **A comprehensive understanding of the social, cultural, economic, demographic and health status characteristics of our uninsured population, including the reasons for their status as uninsured and how Washington's uninsured compare to those in other states.**

We will begin to accomplish this goal through rigorous analysis of the survey data from the 2000 Washington State Population Survey (WSPS) and 1999 National Survey of America's Families (NSAF), and through use of targeted focus groups. The focus groups will be valuable in understanding why Washington continues to have a 10.3 percent uninsured rate given that 70 percent of currently uninsured children and 40 percent of currently uninsured adults have access to either Medicaid, SCHIP or Basic Health. Gaining an understanding of why people are uninsured will allow us to target strategies to maximize use of existing coverage options (public and private), identify gaps in coverage, and develop approaches that induce participation in new and existing health insurance programs.

- **A strategic plan to impose economic and administrative discipline on purchasing, payment, and delivery systems to secure additional money for subsidized health coverage and to provide more affordable coverage for the general market.**

In a national and state environment that will not support employer or individual mandates, we must rely on stabilizing existing delivery, insurance, and purchasing infrastructures, and on achieving administrative efficiencies. Washington State has a long history in bringing public and private purchasers and providers together to address health care access. We will use the planning grant to develop the framework for public/private organizations that will engage, for example, in a series of billing and payment reforms, eligibility information and data transmission reforms, and program regulation reform.

- **A detailed approach to test the viability of community-based delivery and financial flow arrangements that involve public and private purchasers in partnership with local communities and their health care delivery systems.**

The planning grant will be used to develop a detailed work plan and to achieve state governmental commitment to help implement two community-based purchasing arrangements that will seek to stabilize local health care delivery systems and expand access to affordable health coverage. The convergence of the State Planning Grant Program and the Community Access Program provide an ideal environment for state and local collaboration in developing this idea.

- **A six-year "full access" plan that in general will unfold as follows:**

Yr 1	10/00 – 09/01	• Complete planning phase of planning grant Complete analysis of uninsured
Yr 2	10/01 – 09/02	• Submit required state statutory changes or waiver requirements Build administrative/purchasing efficiency initiative infrastructures • Select community-based demonstration sites Monitor changes in uninsured
Yr 3	10/02 – 09/03	• Implement two community-based demonstrations Implement at least two administrative/purchasing efficiency initiatives
Yr 4	10/03 – 09/04	• Monitor changes in uninsured Monitor status and progress on administrative/purchasing initiatives Monitor status and progress on community-based demonstrations
Yr 5	10/04 – 09/05	• Same as year 4 Design formal evaluations of activities to-date
Yr 6	10/05 – 09/06	• Evaluate outcomes of administrative/purchasing efficiency initiatives and community-based demonstrations

This schedule will likely be revised during the Year 1 planning activities. The Report to the Secretary of Health and Human Services will include the final six-year plan, as well as specific results of the planning efforts and lessons learned through this effort.

9. Project Description

Detailed Project Narrative

The state of Washington is applying for this planning grant because of our strong desire to ensure that all residents have access to affordable health insurance benefits. We cannot guarantee that everyone will take advantage of this access, once available, but we can ensure that no systemic barriers exist for those who desire coverage and are persuaded as to its importance. In the following narrative we define the primary goals and objectives for which funding is being sought.

1. Understanding the characteristics of our uninsured population.

Goal: Significantly increase the state's knowledge of why people become uninsured, remain uninsured, and/or transition in and out of insurance*.*

With the additional resources of this grant, Washington State would be uniquely situated to conduct a comprehensive analysis of existing data to more fully understand our uninsured population. We currently have access to the recently completed 2000 Washington State Population Survey (WSPS). The data were obtained from telephone interviews of 7,000 households in the state. The survey is stratified to over-sample ethnic and minority populations to allow for analysis of these populations, and is further stratified to allow for regional analyses. The WSPS data will allow us to determine who Washington's uninsured are, where they reside, and whether they differ significantly from the state's insured population with respect to geographic location, income, and social-demographic attributes.

In addition, we are one of 13 states surveyed by the Urban Institute's 1999 National Survey of America's Families (NSAF) and have access to that data. The Urban Institute's data will allow us to obtain additional detailed information on the uninsured

with respect to their self-reported health status, health care services received, and necessary health care services that were postponed during the last 12 months. The data also will allow us to determine whether there are significant differences between Washington's uninsured and insured populations across these health care factors, and whether there are unique differences between Washington and other states' uninsured populations.

This in-depth data analysis from readily available sources will provide an extensive description of "who" is uninsured in Washington. It will not necessarily provide enough information as to "why" they are uninsured, which we believe is critical for planning. For example, the state's Medicaid/SCHIP programs offer affordable coverage to all children up to 250% of FPL and Basic Health offers subsidized coverage to 200% of FPL. And yet, the 1998 WSPS estimated that some 85,000 children in households below 250% of FPL and 172,000 adults below 200% of FPL were without health insurance.

To address the "why", we propose to conduct a series of focus groups with the uninsured to learn about why they are without coverage. Specific emphasis will be placed on learning about barriers to coverage from the perspective of those who are uninsured. Among the factors to be covered are benefit design preferences (e.g., major-medical coverage for younger populations), premium and cost-sharing elasticity, and marketing and outreach strategies. This better understanding of why our residents are uninsured will give Washington's policy makers needed information to revise current strategies or develop new insurance products and marketing strategies to offer access to coverage.

Objective 1: Create a "point-in-time" profile of the uninsured and reasons for having no coverage.

Anticipated Result: The issue is less one of "who", than of "why". It is important to understand the economic, social, cultural, demographic, and health status characteristics of the uninsured. However, it is more important to understand the nuances of how these characteristics relate to individuals' decisions regarding coverage and their barriers to coverage. For example, are the barriers systemic, perceptual, or educational? It is by understanding the "why" of no coverage that we have a basis for developing new options or revising current strategies.

Tasks: The seven tasks and three deliverables needed to achieve Objective 1 include the following:

- Task 1: Form two advisory / workgroups. There may be some overlap in membership but the charter of each group will differ. The first group is to focus on policy issues; the second group is to focus on technical, data analytic issues. The Project Director will decide final composition of the groups. Project personnel hired as a result of this grant will provide staff support.
- Task 2: Define the questions of interest. Create a policy and technical analysis matrix that articulates (a) each question to which we will turn to the data for an answer, (b) how the answer (if achieved) will help in developing access options, (c) the specific data needed to answer the question, (d) whether the data are currently available or whether a primary data collection effort is needed, and (e) the general analytic approach to be applied to the data. This matrix constitutes ***Deliverable 1***. The Policy and Technical Groups will have responsibility for this task, under the direction of the Project Director and with guidance of a consultant.
- Task 3: Hold review meetings with stakeholders. The Deliverable 1 matrix will provide the basis for gathering input about the desired outcomes and approaches to be used in the data collection and analysis tasks. We anticipate several of these meetings, across the state, to

include a variety of stakeholders such as state policy makers, other governmental entities (e.g., federal, local, Tribal), interested citizens and organizations, employers, purchasers, payers, providers and others. The Project Director will have lead responsibility for this task.

- Task 4: Gather existing data sources. As a result of Tasks 2 and 3, potential data sources will have been identified. This task is the physical collection and collation of the existing sources. Included in this task is the creation of a documented data repository/analytic database. The database and related documentation constitute ***Deliverable 2.*** The consultant and Technical Group will have lead responsibility.
- Task 5: Gather new data. As a result of Tasks 2 and 3, gaps in our existing data sources will have been identified. The purpose of this task is to fill the identified gaps through the design, development, and implementation of additional tools and methodologies, such as targeted focus groups of uninsured residents. The Deliverables associated with this task will be defined based on the results of Tasks 2 and 3. Any new data are to become part of the Task 4 repository/analytic database. The consultant and Technical Group, with input from the Policy Group, will have lead responsibility.
- Task 6: Conduct analyses and make recommendations. This task involves the physical analysis of the data following the general approaches outlined in the Deliverable 1 Matrix. The task concludes with interpretation and recommendations regarding how the findings can be used to inform design decisions regarding future access options. This task will result in ***Deliverable 3*** that will include the analytic results as well as recommendations. Under direction of the Project Director, the consultant will work with the Technical Group for the analysis phase. The Policy Group, with guidance from the consultant and oversight of the Project Director, will have lead responsibility for the interpretation and recommendations phase.
- Task 7: Present results for discussion with stakeholders. Deliverable 3 will form the basis for a discussion with, and input by, stakeholders. As in Task 3, meetings across the state with a variety of persons and organizations are anticipated. The result of these discussions will be needed revisions and then finalization of Deliverable 3. The Project Director has lead responsibility for this task.

Objective 2: Establish a process and tools for the periodic capture and analysis, over time, of the drivers of no coverage.

Anticipated Result: The results of Objective 1 provide the basis for making policy and design decisions in today's world. The point of Objective 2 is to recognize the evolving nature of health care and coverage infrastructures. Reasons for not having access to coverage are likely to change as the market infrastructure changes. For example, if employers move dramatically towards defined contribution approaches, the drivers of un- and underinsurance may change significantly. If we are to maintain the ability to continually evaluate the effectiveness and applicability of our "full access" strategies, we need a mechanism for capturing the evolving nature of personal and systemic barriers.
Tasks: The two tasks and one deliverable needed to achieve Objective 2 include the following:

- Task 1: Design and conduct a feasibility study. The purpose of the feasibility study is to determine the cost-benefit of an on-going effort to stay abreast of changes in reasons for no coverage, as the health market evolves. Questions such as who would maintain the effort, how it would be governed, with what financing, and for what benefit need to be answered. ***Deliverable 4*** would contain the results and recommendations of this analysis. The assumption is that under Objective 1 we will discover that current data sources and analysis processes do not cover the breadth of continuous knowledge needed. One option might be to add a special health component to the WSPS, which is intended to be administered every two-years. The study would be conducted by the

consultant, under direction of the Project Director and with input from the Policy and Technical Groups.

- Task 2: Review design results and recommendations with stakeholders. As with all aspects of this project, it is important to widely and freely solicit the input and feedback of potentially impacted parties. Strategies for doing so include via a dedicated Website as well as in-person forums held throughout the state. The Project Director has lead responsibility for this task.

2. Design Administrative Efficiency Improvement Efforts and Community Based Delivery and Financing Alternatives

Goal: Complete the research and planning work necessary to: (a) establish public/private organization(s) comprised of providers, insurance carriers, state agencies and consumer groups who will agree to undertake a series of administrative reforms over the next six-year period to achieve savings that can be channeled into providing additional subsidized coverage; and (b) work with local community groups to develop the necessary work-plan identify federal/state regulatory changes to implement two pilot projects to demonstrate the feasibility of alternative, community-based models for meeting access needs.

Given Washington State's current health care market environment, we believe there is a unique opportunity for State government to provide a mechanism for public and private payers, health care providers and health carriers to cooperatively reduce the administrative cost of health care through joint initiatives. Washington State has a history of state agency partnerships that have sought to reduce administrative costs of billing and paying for services and contracting for health care coverage through health carriers.

Washington State already has a funding mechanism through its Health Services Account (HSA) to capture monies generated by administrative cost savings. As described in Section 6 of the grant, the HSA is used to finance the subsidized Basic Health (BH), Children's Medicaid and SCHIP programs. Administrative savings that reduce the per-capita growth in programs' premiums will directly translate into funds for additional enrollment.

The Health Care Authority (HCA), Department of Social and Health Services (DSHS), and the Department of Labor & Industries (L&I) have engaged in several joint efforts to achieve common payment systems that simplify billing for providers. The three agencies adopted a common RBRVS for physician payments that uses the same codes, weights and billing procedures. The three agencies will also be adopting the Medicare outpatient prospective payment system (OPPS) for outpatient hospital services. DSHS, HCA and the Office of Insurance Commission (OIC) have sought to develop a common set of health plan provider network reporting requirements. DSHS and HCA have the same collection for BH, Medicaid and public employee plans' provider networks. DSHS and HCA have adopted the same NCQA requirements for their quality assurance contract requirements. The two agencies in partnership with the Department of Health jointly monitor health plans for quality assurance. Both agencies engage in a joint managed care procurement process that has sought to reduce the administrative burden on bidders and the agencies.

Clearly, there is much more that can be done by state purchasers. These efforts can serve as a role model for all payers. However, to achieve further efficiencies, these initiatives should be joint public/private endeavors that involve participation by federal and state government, private payers, health providers and health carriers. The State can play a critical role in facilitating these initiatives because it is the largest purchaser in the state, and it can bring groups together that otherwise could face anti-trust constraints.

Objective 1 - Develop market discipline tools and partnerships to reduce health care costs and expand access.

Anticipated Result: In an environment without health coverage mandates and with limitations on state funds, the primary option for making affordable health coverage available to all citizens is through strategies to reduce health care per-capita cost growth rates. These savings will allow states to afford to offer more subsidized health coverage for low-income residents and to make health insurance more affordable for employers and individuals. For example, a one percent reduction in the growth rate of Washington's Medicaid managed care expenditures equates to the cost of covering 4,000 additional children per year.

Tasks:

- Task 1: Form advisory group. This group will be comprised of representatives from the major provider organizations (e.g., Washington State Hospital Association and Washington State Medical Association), health carriers (e.g., Association of Washington Health Plans), business associations involved with health care purchasing (e.g., Washington Association of Independent Businesses), consumer group representatives, tribal representatives (e.g., American Indian Health Commission in Washington State), state regulatory agencies (DOH and OIC) and state and federal government purchasing agencies (DSHS, HCA, L&I, HCFA), and the SPG Project. The Project Director will be responsible for this task.
- Task 2: Inventory of collaborative administrative efficiency initiatives. While the advisory group is being convened, an inventory of both public and private collaborative efforts currently being undertaken will be assembled. The inventory will focus on billing and payment initiatives, information and data transmission activities, and program regulation activities. It will not include for example, clinic practice and care management initiatives. This inventory will be ***Deliverable 5***. Project staff and consultants will be responsible for this task. Federal and state agency staff will assist in preparing the inventory.
- Task 3: Identification of next generation of administrative simplification initiatives. The advisory group will develop a plan to obtain consensus among payers, providers, and regulators on critical administrative simplification initiatives that should be undertaken. State agencies are aware that there is a strong interest on the part of physician, hospitals and health carriers to develop a single, one-stop provider credentialing process. There also is interest in making insurance eligibility and benefit coverage information more accessible with e-commerce. There already are several organizations offering a portion of this information available online to subscribers. The advisory group will consider whether to convene a series of focus groups, conferences and/or surveys to collect ideas for the next generation. The concensus list of initiatives will be **Deliverable 6**. The advisory group and Project staff will be responsible for this task with consultant assistance.
- Task 4: Identification of regulatory constraints to administrative simplification. A legal analysis will be conducted on existing anti-trust, information confidentially, and regulatory and contract requirements that create barriers to joint public/private administrative initiatives. This analysis will be ***Deliverable 7***. The Project staff, Governor's Executive Policy staff and Assistant Attorney General (AAG) staff will be responsible for this task.
- Task 5: Develop Public/Private Organizations to implement administrative initiatives. Identification and implementation of administrative simplification and e-commerce initiatives

will be an on-going function. There will need to be official public/private organizations that have authority to carry out these functions. The advisory group and Project staff will develop options and necessary state legislation to implement these organization(s). If needed, the Governor will submit necessary legislation to the 2002 State Legislature to constitute these organizations. The organization options and draft legislation will be ***Deliverable 8***.

- Task 6: Implementation plan and initial projects. The advisory group and project staff will prepare a detailed work plan to begin implementing these initiatives by late 2002. The plan will include the design and necessary public/private organizations to undertake these initiatives on an going basis, necessary private and public funding sources to finance these organizations, necessary legislation to implement the organizations, and the list, in priority order, of projects that will be undertaken. This work plan, including the top two priority initiatives will be ***Deliverable 9***.
- Task 7: Standard benefit designs for administrative simplification. Early in the planning grant year, the advisory group will hold a set of special meetings to see whether there is significant interest in consider a set of statewide standardized benefit designs, similar to the standardized benefit approach used for Medicare Supplement insurance. The purpose of this standardization is to reduce the administrative burden on providers and health carriers in having to manage a significant number of benefit designs. If there is sufficient consensus, the Project will develop a revised work plan for reviewing the existing major benefit designs and a process for seeing whether a public consensus can be obtained on the scope of coverage under these designs. If there is not a consensus to undertake a comprehensive review, the Project and state agency staff may undertake a review of state offered coverage based upon the uninsured focus group findings. The results of these meetings and work plan will be ***Deliverable 10***. The Project Director and Governor's Health Policy Advisor will be responsible for this task with input from the advisory committee and technical assistance from the consultants.
- Task 8: Joint purchasing initiatives. The Governor's Health Policy Advisor has requested that HCA and DSHS examine a joint purchasing arrangement for prescription drug coverage purchased through their respective fee-for-service (FFS) arrangements. Prices obtained through these purchasing arrangements will be offered to seniors on a membership basis. Early in the Project's planning year, the advisory group will hold another set of special meetings to assess whether there is significant interest in undertaking joint public/private purchasing initiatives like the state drug purchasing. If there is sufficient interest, the Project will develop a revised work plan to identify purchasing initiatives to be considered and their construction. At a minimum, we will seek consensus on expanding the joint purchasing efforts of the public programs. The results of these meetings and a work plan will be ***Deliverable 11***. The Project Director will be responsible for this task.

Objective 2: Develop a detailed work plan to pilot two community-based purchasing arrangements to achieve 100% access.

Anticipated Result: Faced with growing concern over insurance and delivery system stability, particularly in rural areas, community organizations are starting to develop public/private consortiums to design community-based purchasing arrangements to stabilize their local markets and to expand access. Several of these groups have applied for HRSA Community Access Program (CAP) grants to support their efforts. Other groups also have approached state agencies to assist in their local planning efforts. State Legislative health care committees have expressed interest in having state agencies, such as DSHS and HCA, consider local partnerships that involve direct contracting with rural health provider groups. Although discussions have not begun between the state and Washington's tribes, there may be interest in strengthening and further developing tribal-based purchasing arrangements.

Without technical support from the state and a commitment to participate in local demonstration projects, these community efforts cannot succeed. Therefore, the SPG Project will work with these local initiatives to develop a detailed implementation plan to implement two pilots that use community-based purchasing. The goal is to begin the demonstrations in 2002-2003. Subject to approval by the state legislature and federal government, the projects may have direct access to state and federal funds used to purchase health care coverage for low-income residents.

To be successful, Washington State Executive Policy staff believes that these purchasing arrangements should include participation by local private purchasers and health care providers. A major challenge for these local initiatives will be to obtain necessary commitments from local payers and providers to cooperatively participate in the demonstrations. Although the SPG Project will provide technical assistance, the ability to draw in local payers and community providers will be the responsibility of the community groups.

Tasks:

- Task 1: Form advisory/workgroup. This group will be comprised of persons who are the key policy and technical staff for the local CAP and other community-based groups, such as Spokane County's "Inland Northwest-In-Charge Initiatives", the five-county CHOICE initiative and Jefferson County Critical Access Project. It will include key state and federal (HCFA) agency staff who are responsible for program policy and planning. There may be a need to establish a separate tribal-based workgroup. The Project Director will be responsible for this task.
- Task 2: Define the local access constraints. The workgroup will complete a summary analysis of each community's unique uninsured attributes and service delivery issues. A significant portion of this work will have either begun prior to the SPG or be supported by the CAP grants. Also, the SPG's analysis of the uninsured will focus, to the extent allowed by the data, on attributes of the uninsured that match these communities (e.g., targeted analysis of the uninsured by rural regions). This analysis will be ***Deliverable 12***. The workgroup and Project staff will be responsible for this task.
- Task 3: Define the community-based purchasing strategies. The workgroup with consultant assistance will complete a detailed description of the purchasing models that could be tested. It will include how the purchasing arrangements would be structured, what types of coverage would be offered, who would have access to the purchasing arrangements, and geographic boundaries. It is not assumed that there would be a single model. It is important to give the local entities flexibility to design their own approaches. The description of the purchasing models will be ***Deliverable 13***. The local community groups will be primarily responsible for this task. To the extent possible, state agency staff will be made available to assist the groups with their design efforts.
- Task 4: Identify the major federal and state statutory constraints. The workgroup will review existing federal and state laws and rules to determine what waivers and statutory changes would be needed to implement community-based purchasing demonstrations. A plan will be developed on how these barriers will be addressed (e.g., obtain necessary 1115 waivers for Medicaid/SCHIP funds to be used to finance coverage). This will be ***Deliverable 14***. Project and state agency staff will be responsible for this task.
- Task 5: Identify the major local business, labor, health providers and advocacy groups. The individual community purchasing groups will identify their major public and private payers and providers. A stakeholder plan will be developed on how these groups will participate in the demonstrations. This plan will be ***Deliverable 15***. The local community groups will be responsible for this task.

- Task 6: Obtain necessary federal and state law, rule or waiver changes to allow for implementation of community-purchasing demonstrations. The Governor's Executive Policy Office will, in coordination with necessary state agencies, submit necessary legislation and waiver requests for the demonstrations. The Task 3 document will describe what needs to be done. However, the actual law or waivers would not be sought during the grant year. They would be obtained as part of the implementation requirements.
- Task 7: Implementation Plan. The workgroup would prepare a detailed implementation plan for a multi-year demonstration project. The plan will include the deliverables outlined above. It also would include the necessary tasks and time frames to implement the demonstration. It will also include an evaluation design. Both the workgroup and SPG project staff will be responsible for this task. The plan will be ***Deliverable 16***. To the extent possible, state and federal agency staff would provide technical assistance in preparing the plan.

3. Report to the Secretary

Goal: Submit a detailed report to the Secretary in the format developed by Federal program staff by September 30, 2001.

Anticipated Result: The detailed report will include the deliverables described in the above project tasks. The report will be organized to include:

- A detailed analysis of who Washington State's uninsured are, why they are uninsured, and coverage, cost-sharing and marketing options to increase participation;
- Formal public/private mechanisms and an identified list of administrative efficiency initiatives to reduce the growth rate in health care costs, which will allow the state to expand subsidized enrollment and make health insurance more affordable to the general public; and,
- Detailed work plans (and commitment by state government) to partner with two community groups to jointly implement community-based purchasing projects that will expand access to health insurance and help stabilize local markets.

The Project is designed to have a set of deliverables that are produced throughout the planning year. These deliverables will serve as the basis for the final report and will be report appendices. The Project Director and staff will be responsible for preparing the final report

Tasks:

- Task 1: Convene a SPG Advisory Committee. This committee will be comprised of representatives from the major provider organizations (e.g., Washington State Hospital Association and Washington State Medical Association), health carriers (Association of Washington Health Plans), business associations involved with health care purchasing (Association of Washington Business), consumer group representatives, tribal representatives (American Indian Health Commission in Washington State), community-based groups developing purchasing options (e.g., Inland Northwest-In-Charge Initiative, CHOICE, and Jefferson County Critical Access Project), state regulatory agencies (DOH and OIC) and state and federal government purchasing agencies (DSHS, HCA, L&I, and HCFA), and the SPG Project. The committee will be responsible for monitoring the three project areas, participate in forums, and evaluate and make final report recommendations on the options developed by the administrative efficiency and community-purchasing workgroups. The committee membership and meeting reports will be ***Deliverable 17***. The SPG Project Director and Governor's Health Policy Advisor will be responsible for this task.

- Task 2: Monitor and Review Deliverables. The SPG Advisory Committee, SPG Project Director and Governor's Health Policy Advisor will monitor the project status and review project deliverables. The Project Director will submit draft deliverable reports to the federal project manager for review and comment.

- Task 3: Final Report. The Project will submit a final report to the Secretary by September 30, 2001. The Project Director is responsible for this task.